DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445296	A. BUILDING _____ B. WING _____	08/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF EAST RIDGE	1500 FINCHER AVENUE EAST RIDGE, TN 37412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, manufacturer's recommendation, and interview, the facility failed to ensure the correct application of a restraint for one (#31) of two residents reviewed for restraint usage. The findings included: Resident #31 was admitted to the facility on December 22, 2009, with diagnoses including Alzheimer's Dementia, Altered Mental Status, and Ischemic Heart Disease. Medical record review of resident #31's Minimum Data Set dated June 12, 2012, revealed the resident had impaired short and long term memory, required extensive assist of two for transfers and ambulation, and used a trunk restraint daily. Medical record review of the August 2012 physician's orders revealed "...November 23, 2011...Click seatbelt to w/c (wheelchair)..." and "...March 20, 2012...Tilt in space w/c while out of bed for positioning..." Observation on August 13, 2012, at 12:30 p.m., in the second floor dining room revealed the	F 221	This plan of correction is submitted and required under Federal and State regulations and statutes applicable to long term care providers. The plan of correction does not constitute an admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan of correction does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited is correctly applied.	9/11/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X5) DATE 8/29/12

...y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ...lowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ...ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ...ogram participation.

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F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, manufacturer's recommendation, and interview, the facility failed to ensure the correct application of a restraint for one (#31) of two residents reviewed for restraint usage. The findings included: Resident #31 was admitted to the facility on December 22, 2009, with diagnoses including Alzheimer's Dementia, Altered Mental Status, and Ischemic Heart Disease. Medical record review of resident #31's Minimum Data Set dated June 12, 2012, revealed the resident had impaired short and long term memory, required extensive assist of two for transfers and ambulation, and used a trunk restraint daily. Medical record review of the August 2012 physician's orders revealed "...November 23, 2011...Click seatbelt to w/c (wheelchair)..." and "...March 20, 2012...Tilt in space w/c while out of bed for positioning..." Observation on August 13, 2012, at 12:30 p.m., in the second floor dining room revealed the	F 221	F221 1. On 8/15/2012 nursing and therapy ensured resident #31's seat belt was adjusted appropriately to fit close to the body for safety. Maintenance removed second seat belt from resident #31's wheel chair. 2. Other residents with seat belts were inspected by the nursing staff and all were in compliance. 3. The Staff Development Coordinator and Director of Nursing conducted an educational in-service to the nursing staff regarding the safe application of seat belts. The Treatment administration records of residents with seat	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

ED 8/29/12

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 221	Continued From page 1 resident had a seat belt on in the wheelchair, loosely applied allowing the buckle to be approximately four inches from the knees. Observation on August 14, 2012, at 9:00 a.m., at 2:00 p.m., and 4:30 p.m., revealed the resident had a seat belt on in the wheelchair, loosely applied, allowing the buckle to be approximately four inches from the knees. Observation on August 14, 2012, at 10:45 a.m., in the resident's room with the resident's spouse revealed the resident was able to raise the seatbelt up above the wheelchair arms and was fiddling with it, and did not try to release the seatbelt. Interview at that time with the spouse revealed the seatbelt is usually that loose. Observation and Interview, on August 15, 2012, at 12:45 p.m., with the resident's spouse and Physical Therapist (PT) #1 on the front porch of the facility, revealed the resident sitting in the tilt in space wheelchair with the spouse sitting on a swing next to the resident. Continued observation revealed the resident had two seatbelts applied to the wheelchair. Continued observation with PT #1 revealed one section (right side of w/c) of the four sections was tied around the w/c back post close to the seat, and the second section was hooked into the buckle on the left side of the wheelchair, and the fourth section was hanging next to the left side of the wheelchair. Review of the manufacturer's recommendation revealed a picture of the safety belt but no instructions how to apply the seat belt for resident safety.	F 221	belts were updated on 8/23/2012 to add: check for safe application of seat belts while in use. The Director of Nursing or designee will conduct random seat belt audits 3 times a week for 4 weeks, then at least 5 times a month for 2 months to ensure compliance. 4. The Director of Nursing will report seat belt audits monthly to the Quality Assurance Committee, consisting of a physician, director of nursing and three other staff members for 3 months. The Executive Director will monitor this process monthly to ensure continued compliance.	

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F 221	Continued From page 2 Interview with PT #1 on August 15, 2012, at 12:50 p.m., on the front porch confirmed the seat belts were confusing and could lead to the resident not being safe. Continued interview revealed when the seat belt is correctly applied the seatbelt should be close to the body for safety.	F 221	F241 1. On 8/15/2012 nursing ensured resident #145's catheter bag was covered.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain dignity for one (#145) of twenty-seven Stage 2 sampled residents. The findings included: Resident #145 was admitted to the facility on July 2, 2012, with diagnoses of Muscle Weakness, Alzheimer's Type Dementia, Dislocated Hip, and Anemia. Observation on August 13, 2012, at 1:00 p.m., revealed resident #145 lying in bed with eyes closed. Further observation revealed the resident had an indwelling catheter which was connected to an exposed drainage bag hanging on the bottom rail of the resident's bed. Observation and interview with Licensed Practical Nurse (LPN) #6 on August 15, 2012, at 10:00	F 241	2. The nursing staff inspected other residents with catheter bags and all were in compliance. 3. The Staff Development Coordinator and Director of Nursing conducted an educational in-service to the nursing staff regarding applying covers to catheter bags. The Director of Nursing or designee will conduct random catheter cover audits 3 times a week for 4 weeks, then at least 5 times a month for 2 months to ensure compliance.	9/11/12

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F 241	Continued From page 3 a.m., confirmed the resident had an indwelling catheter connected to an uncovered drainage bag which was attached to the bed. Interview at that time with LPN #1 confirmed the resident's catheter bag is to be covered at all times to preserve the resident's dignity.	F 241	4. The Director of Nursing will report catheter cover audits monthly to the Quality Assurance Committee consisting of a physician, director of nursing and three other staff members for 3 months. The Executive Director will monitor this process monthly to ensure continued compliance.	
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify one resident (#116) of changes in roommate assignments, of seventeen Stage One residents and three families interviewed. The findings included: Resident #116 was admitted to the facility on June 6, 2012, with diagnoses including Aftercare Right Hip Fracture with Surgical Intervention, Muscle Weakness, Hypertension, Osteoporosis, and Osteoarthritis. Medical record review of the Minimum Data Set dated June 22, 2012 and July 6, 2012, revealed the resident to be cognitively intact with BIMS (Brief Interview for Mental Status) Scores of 13/15 on both dates. Review of facility admission documentation dated June 6, 2012, revealed the resident was	F 247	F247 1. Resident #116 was notified of his roommate changes on 8/15/12. 2. The Social Service staff has notified all other residents of roommate changes. 3. The Executive Director conducted an educational in-service	9/11/12

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F 247	Continued From page 4 competent and legally responsible. Interviews with the resident on August 13, 2012, at 2:00 p.m., in the resident's room, and on August 15, 2012, at 1:15 p.m., in the resident's room, revealed the resident stated "...had moved to the current room per self-request on June 29, 2012, and had four different roommates since the move but had not been notified before any of the new roommates arrived." Medical record review of the electronic Progress Note Review dated July 3 through August 3, 2012, which included electronic charting from nursing, dietary, and social service departments, revealed no documentation of resident notification of roommate changes from nursing or social services. Interview with the Social Services Director, on August 15, 2012, at 10:30 a.m., in the facility lobby, confirmed residents were to be notified of roommate changes prior to the roommate change occurring and the facility had failed to notify resident #116 of new roommates.	F 247	to the Social Services department regarding the importance of providing notification to residents regarding room changes and roommates. The Social Service director conducted an educational in-service of nursing staff on 8/23/12 regarding providing proper notification of residents when there is a change in rooms or roommates. The Social Service director will conduct random audits 3 times a week for 4 weeks of notification regarding room changes and roommate moves, then at least 5 times a month for two months to ensure compliance. 4. The Social Service Director will report her	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, the facility failed to provide services to meet professional standards of care during medication administration to ensure an	F 281		9/14/12

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F 247	Continued From page 4 competent and legally responsible. Interviews with the resident on August 13, 2012, at 2:00 p.m., in the resident's room, and on August 15, 2012, at 1:15 p.m., in the resident's room, revealed the resident stated "...had moved to the current room per self-request on June 29, 2012, and had four different roommates since the move but had not been notified before any of the new roommates arrived." Medical record review of the electronic Progress Note Review dated July 3 through August 3, 2012, which included electronic charting from nursing, dietary, and social service departments, revealed no documentation of resident notification of roommate changes from nursing or social services. Interview with the Social Services Director, on August 15, 2012, at 10:30 a.m., in the facility lobby, confirmed residents were to be notified of roommate changes prior to the roommate change occurring and the facility had failed to notify resident #116 of new roommates.	F 247	findings to the Quality Assurance Committee, consisting of a physician, director of nursing and three other staff members consisting of a physician, director of nursing and three other staff members for 3 months. The Executive Director will monitor this process monthly to ensure continued compliance.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, the facility failed to provide services to meet professional standards of care during medication administration to ensure an	F 281		9/11/12

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F 281	Continued From page 5 accurate dosage of a medication was administered and reported accurately and timely for one (#202) of eleven residents observed for medication administration The findings included: Observation on August 14, 2012, at 9:45 a.m., near resident #202's room revealed LPN #4 prepared the resident's medications. Continued observation revealed LPN #4 obtained a packet with a tablet enclosed from a box in the medication drawer labeled Losartan 25 mg, placed the tablet into a medication cup and administered the Losartan to resident #202 in the resident's room. Continued observation of the packet the Losartan was obtained from stated "Losartan 50 mg." Observation of the box the Losartan was taken from in the medication cart revealed a label stating Losartan 25 mg, was delivered to the facility on July 25, 2012, and contained four more Losartan 50 mg tablets. Medical record review of resident #202's Physician's Orders for August 2012 revealed "...Losartan 25 mg PO (by mouth) daily..." Interview with LPN #4 on August 14, 2012, at 10:10 a.m., at the 200 nurse's desk confirmed 50 mg of Losartan was administered to the resident instead of the 25 mg the physician ordered, and "the pharmacy must have sent the wrong dose." Interview on August 15, 2012, at 3:00 p.m., in the Director Of Nursing (DON)'s office with the DON revealed the DON stated LPN #4 had told the DON about the incorrect doses of the medication in the box but had also told the DON the surveyor	F 281	**F281** 1. All 50mg tablets of Losartan were removed from resident #202's medication cart drawer. On 8/15/12 nursing staff notified resident #202's physician and family regarding the dosage of Losartan given. Resident #202's vital signs were monitored, with no abnormal findings. Resident was discharged safely home on 8/16/2012. 2. On 8/15/12 the pharmacy staff reviewed all other prescriptions with actual dosages on hand and all were found to be in compliance. 3. The Staff Development Coordinator and Director of Nursing conducted an educational in-service	9/11/12

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F 281	Continued From page 6 had intervened prior to the wrong dose being given to the resident. Continued interview with the DON revealed the DON had notified the resident's physician about the wrong doses of Losartin in the box but had received the correct had been given. Interview on August 15, 2012, at 3:45 p.m., in the DON's office revealed LPN #4 was re-interviewed and had admitted resident #202 had received 50 mg of Losartan instead of the 25 mg the physician had ordered. Continued interview revealed the DON had notified resident #202's physician of the medication error. Continued interview revealed the resident's blood pressure and pulse had been obtained on August 14, 2012, and were within the resident's normal parameters. Continued interview revealed resident #202's blood pressure and pulse were obtained at 3:10 p.m., on August 15, 2012, and were within the resident's normal parameters. Continued interview confirmed LPN #4's had failed to meet professional standards of care during medication administration by ensuring the correct dose was administeredand to accurately report a medication error.	F 281	on the 5 rights of medication administration to the nursing staff. The Director of Nursing or designee will conduct random observations of medication passes 3 times a week for 4 weeks, then at least 5 times a month for two months to ensure compliance. 4. The Director of Nursing will report medication pass audits monthly to the Quality Assurance Committee, consisting of a physician, director of nursing and three other staff members for 3 months. The Executive Director will monitor this process monthly to ensure continued compliance.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, facility policy review, and interview, the facility	F 332		9/11/12

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F 332	Continued From page 7 failed to administer six of sixty-six medications without error, resulting in a nine percent medication error rate. The findings included: Observation on August 14, 2012, at 9:40 a.m., in the hallway near resident #31's room revealed Licensed Practical Nurse (LPN) #4 prepared resident #31's medications. Continued observation revealed LPN #4 placed one Enteric Coated Aspirin 81 mg (milligram) into a medication packet and crushed the tablet, poured the crushed tablet into a medication cup added applesauce and administered the crushed tablet to resident #31 in the resident's room. Medical record review of resident #31's Physician's Orders for August 2012 revealed "...Aspirin (Baby) 81mg Tablet EC (Enteric Coated)...Take 1 Tab by mouth every day..." Review of facility policy, Medication Crushing - General Guidelines & List of Medications, revealed "...The rationale for not crushing some medications includes...Enteric Coated Tablets are designed to pass through the stomach whole and then dissolve in the intestinal tract..." Interview with LPN #4 on August 14, 2012, at 10:10 a.m., at the 200 nurse's desk confirmed the Enteric Coated Aspirin was crushed prior to administration and Enteric Coated Tablets are not to be crushed. Medical record review of resident #202's Physician's Orders for August 2012, revealed "...Losartan 25mg PO (by mouth) daily..."	F 332	F332 1. All 50mg tablets of Losartan were removed from resident #202's medication cart drawer. On 8/15/12 nursing staff notified resident #202's physician and family regarding the dosage of Losartan given. Resident #202's vital signs were monitored, with no abnormal findings. Resident was discharged safely home on 8/16/2012. On 8/14/12 nursing staff notified resident #31's physician and family regarding the method of Enteric coated aspirin given. Resident #31 was monitored for GI symptoms, with no abnormal findings. Nursing staff gave	9/11/12

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F 332	Continued From page 8 Observation on August 14, 2012, at 9:45 a.m., near resident #202's room revealed LPN #4 prepared the resident's medications. Continued observation revealed LPN #4 obtained a packet with a tablet enclosed from a box in the medication drawer labeled Losartan 25 mg. Continued observation revealed LPN #4 placed the tablet into a medication cup and administered the Losartan to resident #202 in the resident's room. Continued observation of the packet the Losartan was obtained from stated "Losartan 50 mg." Interview with LPN #4 on August 14, 2012, at 10:10 a.m., at the 200 nurse's desk confirmed 50 mg of Losartan was administered to the resident instead of the 25 mg the physician ordered. Observation on August 14, 2012, at 9:55 a.m., in the hallway near resident #142's room revealed Licensed Practical Nurse (LPN) #4 prepared resident #142's medications. Continued observation revealed LPN #4 obtained one Enteric Coated Aspirin 81 mg tablet, placed the tablet into the medication cup, and administered the Enteric Coated Aspirin to resident #142 in the resident's room. Medical record review of resident #142's Physician's Orders for August 2012 revealed "...Aspirin Children's 81mg Tab Chew {chewable}...take 1 tab by mouth every day..." Interview with LPN #4 on August 14, 2012, at 10:10 a.m., at the 200 nurse's desk confirmed Enteric Coated Aspirin 81 mg was administered	F 332	next dose of 81mg Aspirin appropriately. Nursing staff notified nurse practitioner of enteric coated aspirin given to resident #142. Nursing staff properly administered the next and following doses of the chewable 81mg baby aspirin. On 8/14/12 LPN #1 was in-serviced on importance of administering complete dose of Miralax powder and educating resident on waiting one minute in between Symbicor and Spiriva inhalants. Nursing staff notified resident # 303's physician and family regarding the administration of Spiriva given. Resident was found to have no adverse effects.	

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F 332	Continued From page 9 to resident #142, and the physician's order was for the Aspirin to be in the chewable form and not the Enteric Coated form that was administered to the resident. Medical record review of the Physician Recapitulation Orders signed August 7, 2012, revealed "...Miralax Powder 17 GMS (grams) in 8 oz (ounces) of water...Symbicort 160 - 4.5 MCG (micrograms) inhaler 2 puff twice daily...Spiriva 18 MCG (micrograms)...1 capsule...daily..." Observation of the medication preparation for resident #303 on August 14, 2012, at 8:38 a.m., revealed LPN #1 obtained Miralax powder 17 grams, mixed in 8 oz's of water, Symbicort 160-4.5 mcg inhaler, and a Spiriva 18 mcg (microgram) handihaler from the medication cart. Observation on August 14, 2012, at 8:40 a.m., revealed LPN #1 gave the Miralax mixture to resident #303, who drank approximately half of the 8oz. mixture. Continued observation revealed LPN #1 gave the Symbicort inhaler to resident #303 without providing instructions for the resident on how to use the inhaler. Continued observation revealed LPN #1 administered the Spiriva handihaler to resident #303 without providing instructions to the resident. Observation revealed resident #303 asked LPN #1 about rinsing the mouth. LPN #1indicated to the resident to use the remaining Miralax mixture to rinse the mouth. Further observation revealed resident #303 rinsed the mouth with the Miralax and spit in the remaining mixture.	F 332	Nursing staff properly administered the next dosage of Spiriva, providing proper instruction on how to correctly use Spiriva and inhalant medications. 2. On 8/15/12 the pharmacy staff reviewe d all other prescriptions with actual dosages on hand all were found to be in compliance. 3. The Staff Development Coordinator and Director of Nursing conducted an educational in-service on the 5 rights of medication administration to the nursing staff and providing professional services to residents as per professional standards of quality. The Director of Nursing or designee	

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F 332	Continued From page 10 Review of facility policy on "...How to Use a Metered Dose Inhaler..." revealed, "...3. Have the resident tilt his or her head back slightly and breathe out as much air as possible. 4. Put the inhaler mouthpiece in the resident's mouth past the teeth and above the tongue. 5. As the resident takes a slow, deep breath, press the button on the inhaler once. 6. After the resident has taken as much breath as possible, tell him or her to hold their breath to count of ten. 7. Tell the resident to breathe out as slowly as possible ...Note Repeat steps 3 through 7 for each additional puff ordered by the physician, waiting at least one minute between each puff..." Interview with LPN #1 on August 14, 2012, at the 300 hall nurses station at 9:40 a.m., confirmed the resident had not been instructed or given an explanation regarding the use of the Symbicort or the Spiriva handihaler. Continued interview confirmed resident #303 had not received the full dose of the Miralax.	F 332	will conduct random observations of medication passes 3 times a week for 4 weeks, then at least 5 times a month for 2 months to ensure compliance. 4. The Director of Nursing will report medication pass audits monthly to the Quality Assurance Committee, consisting of a physician, director of nursing and three other staff members for 3 months. The Executive Director will monitor this process monthly to ensure continued compliance.	9/11/12
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 425	F425 1. All 50mg tablets of Losartan were removed from resident #202's medication cart drawer.	

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F 425	Continued From page 11 the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, the facility failed to provide accurate dosage of medication for one (#202) of eleven residents observed for medication administration The findings included: Observation on August 14, 2012, at 9:45 a.m., near resident #202's room revealed LPN #4 prepared the resident's medications. Continued observation revealed LPN #4 obtained a packet with a tablet enclosed, from a box in the medication drawer labeled Losartan 25 mg, placed the tablet into a medication cup and administered the Losartan to resident #202 in the resident's room. Continued observation of the packet the Losartan was obtained from stated "Losartan 50 mg." Observation of the box the Losartan was taken from in the medication cart revealed a label stating Losartan 25 mg had been delivered to the facility on July 25, 2012, and contained four more Losartan 50 mg tablets. Medical record review of Physician's Orders for August 2012 revealed "...Losartan 25mg PO (by	F 425	On 8/15/12 nursing staff notified resident #202's physician and family regarding the dosage of Losartan given. Resident #202's vital signs were monitored, with no abnormal findings. 2. On 8/15/12 the pharmacy staff reviewed all other prescriptions with actual dosages on hand and all were found to be in compliance. 3. The Staff Development Coordinator and Director of Nursing conducted an educational in-service on the 5 rights of medication administration to the nursing staff. The Director of Nursing or designee will conduct random observations of medication passes 3	

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F 425	Continued From page 12 mouth) daily..." Interview with LPN #4 on August 14, 2012, at 10:10 a.m., at the 200 nurse's desk confirmed 50 mg of Losartan was administered to the resident instead of the 25 mg the physician ordered and "the pharmacy must have sent the wrong dose." Interview on August 15, 2012, at 3:00 p.m., in the Director Of Nursing (DON)'s office with the DON revealed the four 50mg tablets of Losartan were removed from the medication cart on August 14, 2012, after Licensed Practical Nurse (LPN) #4 reported the error. Continued interview with the DON confirmed the Losartan 50 mg was in resident #202's drawer by error and contributed to the medication error.	F 425	times a week for 4 weeks, then at least 5 times a month for 2 months to ensure compliance. 4. The Director of Nursing will report medication pass audits monthly to the Quality Assurance Committee, consisting of a physician, director of nursing and three other staff members for 3 months. The Executive Director will monitor this process monthly to ensure continued compliance.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		9/11/12

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F 441	Continued From page 13 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview the facility failed to prevent cross contamination through infection control practices for hand hygiene, medication preparation, and the distribution of ice in an unsanitary manner. The findings included: Observation on August 13, 2012, at 10:40 a.m., revealed Licensed Practical Nurse (LPN) #5 administered medications to the resident in room 210A, and exited the resident's room without disinfecting the hands. Continued observation revealed LPN #5 went to the medication cart and charted the medications given. Continued observation revealed LPN #5 went to the nurse's station, and then to the food pantry to get a	F 441	F441 1. This facility requires staff to wash their hands after direct resident contact. The staff observed were immediately informed of the proper hand washing procedure and ice scoop policy by nursing administration. 2. No other observations were made of not following the hand washing procedure and ice scoop policy. 3. The Staff Development Coordinator and Director of Nursing conducted an educational in-service on proper hand washing technique and ice scoop policy. The Director of Nursing or designee will conduct random observations of hand washing and ice	9/11/12

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F 441	Continued From page 14 sandwich for a resident. Continued observation revealed LPN #5 was not able to locate the resident, put the sandwich back in the refrigerator in the pantry, and returned to the medication cart. Review of facility policy, Hand Hygiene, revealed "...Handwashing/hand hygiene is generally considered the most important single procedure for preventing nosocomial infections..." Interview with LPN #5 on August 13, 2012, at 10:45 a.m., at the medication cart confirmed the hands had not been disinfected after administering medication to the resident in room 210A. Continued interview confirmed, "...forgot to disinfect hands...should have disinfected the hands before leaving the resident's room." Observation on August 13, 2012, at 2:47 p.m., at the 100 nurse's desk revealed Licensed Practical Nurse #1 and #3 were completing the narcotic reconciliation. Continued observation revealed LPN #3 obtained approximately ten medication cups and placed them one by one onto the medication cart using the bare hands and put the index finger in each cup, contaminating each cup. Continued observation revealed LPN #3 obtained a bottle of medications from the medication cart with the bare hands, opened the lid and put the index finger into the bottle of pills and pulled several pills out one by one contaminating them, and placing the pills into the contaminated medication cups. This process continued for one more bottle of pills, with LPN #1 observing. Interview with LPN #1 and LPN #3 on August 13,	F 441	scoop usage 3 times a week for 4 weeks, then at least 5 times a month for 2 months to ensure compliance. 4. The Director of Nursing will report hand washing and ice scoop audits monthly to the Quality Assurance Committee consisting of a physician, director of nursing and three other staff members for 3 months. The Executive Director will monitor this process monthly to ensure continued compliance.	

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F 441	Continued From page 15 2012, at 2:57 p.m., at the 100 nurse's desk confirmed the medication cups, the bottles and the pills were contaminated when touched by the bare hands/finger. Observation on August 13, 2012, at 11:54 a.m., on the 300 hall revealed Certified Nursing Assistant (CNA) #1 and CNA #2 passing lunch trays and obtaining ice from a cooler. Continued observation revealed CNA #1 passed lunch trays to 3 rooms using a plastic drinking cup stored in the ice chest as a scoop to remove the ice from the ice chest, and place the ice in the resident's glass. Observation at 12:05 p.m., revealed CNA #2 obtained ice from the same cooler using the plastic drinking cup as a scoop to put ice in another resident's glass. Review of facility policy, Ice Chests and Machines, revealed "...Hold scoop used with the ice chest by handle; do not touch bowl surface with hands...Ice scoops should be smooth and impervious and should be kept on an uncovered stainless steel, impervious plastic, or fiberglass tray on top of the chest or in a mounted holder when not in use..." Interview on August 13, 2012, at 12:11 p.m., on the 300 hall with CNA #1 and #2, confirmed an ice scoop was available in the ice scoop holder, and using the cup stored inside the ice chest to fill residents' glasses was not a sanitary practice.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502	F502 1. On 8/15/12, an order was written by the physician to discontinue the two	9/11/12

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F 502	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain laboratory specimens as ordered for one (#145) of twenty-seven Stage 2 sampled residents. The findings included: Resident #145 was re-admitted to the facility on July 2, 2012, with diagnoses of Muscle Weakness, Alzheimer's Type Dementia, and Anemia. Medical record review revealed a physician's order dated July 12, 2012, for "...stool specimen x 3 to r/o (rule out) blood in stool." Medical record review revealed one stool specimen was obtained on July 12, 2012, with results of positive for blood. Medical record review revealed no further documentation of labs obtained. Interview with the Unit Manager at the Unit One Nursing Station, on August 15, 2012, at 2:15 p.m., confirmed one lab was obtained and found to be positive for blood and there was no documentation the other two labs were obtained as ordered. Medical record review of a physician's order dated July 25, 2012, revealed "Stool specimen x 3 for C-Diff (Clostridium Difficile) re: diarrhea..." Medical record review revealed no documentation the stool specimens for C-Diff were obtained.	F 502	remaining stool sample labs for resident #145. 2. All other residents with stool sample orders were found to be in compliance. 3. The Staff Development Coordinator and Director of Nursing conducted an educational in-service to the nursing staff regarding the completion of all physician orders and documenting results of labs in residents' charts. The Director of Nursing or designee will conduct random stool sample order audits 3 times a week for 4 weeks, then at least 5 times a month for 2 months to ensure compliance.	

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F 502	Continued From page 17 Further medical record review revealed a stool specimen was obtained on July 26, 2012, but was not tested for C-Diff. Interview with the Unit Manager at the Unit One Nursing Station on August 15, 2012, at 2:15 p.m., confirmed the labs were not obtained as ordered. Interview with the resident's physician on August 15, 2012, at 2:40 p.m., confirmed the resident's stool specimen which was obtained on July 26, 2012, had not been tested for C-Diff and the physician's orders had not been followed.	F 502	4. The Director of Nursing will report stool sample order audit results monthly to the Quality Assurance Committee consisting of a physician, director of nursing and three other staff members for 3 months. The Executive Director will monitor this process monthly to ensure continued compliance.	